Faces of the Uninsured and State Strategies To Meet Their Needs: A Briefing Paper

Arizona Health Care Cost Containment System

July 2001

Faces of the Uninsured and State Strategies To Meet Their Needs: A Briefing Paper

Arizona Health Care Cost Containment System

July 2001

William M. Mercer, Incorporated
3131 E Camelback Road
Suite 300
Phoenix, AZ 85016

602 522 6500

Contents

Executive Summary

The number of uninsured in the United States has grown by nearly 10 million people over the past decade, reaching nearly 42 million Americans in 1999, or approximately 18% of the total non-elderly population. This growing number of uninsured has also had a major impact on Arizona (State). By 1999, Arizona had one of the highest rates of uninsured of non-elderly persons. Based on pooled estimates from March 1998, 1999, and 2000, of the State's approximately 4.2 million non-elderly residents, 26% of them were lacking health care coverage.

William M. Mercer, Incorporated (Mercer) has produced this briefing paper for the Arizona Health Care Cost Containment System (AHCCCS) as part of the Arizona State Planning Grant, which is funded by the Health Resources and Services Administration (HRSA). It is important to note that this is one in a series of papers provided as a tool for policy makers as part of the HRSA grant process to develop strategies to increase access to health care in Arizona. The Statewide Health Care Insurance Plan Task Force (Task Force) will be placed with the responsibility of developing plans for providing Arizona uninsured populations with affordable, accessible health insurance.

Faces of the Uninsured

The uninsured population is not a single, homogeneous population. It is actually comprised of a number of smaller sub-populations, formed by several key drivers of uninsurance which include Age, Employment (status and size), Income (relative to poverty level), Ethnicity, and Geography (urban vs. rural).

After examination of these drivers, based on Arizona-specific information, several sub-populations for Arizona were identified. These sub-populations are large enough to merit a closer look, as they will help address the factors that cause people to be uninsured in Arizona.

The sub-populations and their key focal groups have been identified as:

Sub-Population	**Focal Group**
Low-Income Uninsured	Low-Income Uninsured Children and their Parents
Ethnic Uninsured	Low-Income Hispanic Uninsured
Working Uninsured	Working Uninsured in Small Employers
Rural Uninsured	Rural Low-Income Uninsured Children and their Parents

These groups are not mutually exclusive, and many individuals fall into more than one of these sub-populations. The Rural Health Office has been tasked with providing policy makers with additional insight into the non-duplicative sub-populations.

Key Focus for Arizona Policy Makers

Low-Income Uninsured: Children and their Parents

Low-Income Uninsured are defined as family units with incomes below 200% of the Federal Poverty Level (FPL). In Arizona, nearly three-quarters (74%) of the uninsured reside in family units with incomes below 200% of the FPL. Separating the Low-Income Uninsured by age provides some insight into where policy makers should focus their resources. By focusing on the Low-Income Uninsured children and their parents, almost two-thirds (65%) of the Low-Income Uninsured can be addressed. This statistic indicates a need to examine Low-Income Children and their Parents in Arizona as a key focus among the Low-Income Uninsured population.

This sub-population is best addressed by State/Federal programs, such as Medicaid and State Children's Health Insurance Program (SCHIP).

Ethnic Uninsured: Low-Income Hispanic Uninsured

The Ethnic Uninsured are defined as citizen and non-citizen non-white uninsured. Uninsurance rates by ethnicity for Arizona show that Hispanics have a rate of 45%, compared to 19% for non-Hispanic whites, and 23% for African-Americans. For Low-Income Hispanics, the uninsurance rate is even higher at 53%. This disparity of uninsurance rates by ethnicity is extremely significant, as it also skews the relative distribution of the uninsured in Arizona. The Hispanic population comprises only one-quarter (25%) of the entire Arizona population, while they represent more than half of the uninsured (52%) in Arizona. This indicates a need to examine Low-Income Uninsured Hispanic in Arizona as a key focus among the ethnic uninsured.

Although no program has a high level of impact on this sub-population, there has been moderate success in all categories.

Working Uninsured: Working Uninsured in Small Employers

The Working Uninsured are defined as those family units with at least one full-time worker. With 84% of the uninsured in a family unit with at least one worker, simply being a worker in the Arizona employment arena does not mean that employer-based health care coverage is offered. Also, Arizona's economy is dominated by small employers, who are the least likely to offer insurance. Ninety-seven percent of Arizona's employers consist of fewer than 100 employees, compared to a National average of only 41%. Therefore, it is important to focus on the Working Uninsured in Small Employers in Arizona as a key group that makes up a large number of this uninsured population.

This sub-population is best addressed by Market-Based reforms, such as tax incentives and subsidies for small employers.

Rural Uninsured: Rural Low-Income Uninsured Children and their Parents

The Rural Uninsured are defined as those family units not living adjacent to a Metropolitan Statistical Area (MSA). In the United States, individuals living in rural areas have a much higher

uninsurance rate (22%) than their urban counterparts (15%), and this rate increases the farther an individual lives from an urban area. Nationally, 67% of the uninsured residing in rural areas have family incomes of less than 200% of the FPL. By focusing on the Rural Low-Income Uninsured Children and their Parents, almost two-thirds (64%) of the Rural Low-Income Uninsured can be addressed. This indicates a need to examine the Rural Low-Income Uninsured Children and their Parents in Arizona as a key focus among this sub-population.

Although no program has a high level of impact on this sub-population, State/Federal Programs and State and Local Initiatives have had moderate success, particularly purchasing pools and universal coverage initiatives.

The specific strategies and their impact on Arizona's uninsured sub-populations are discussed in further detail below.

Strategies

Several states have implemented a variety of strategies to reduce the size of their uninsured populations. The following strategies used by various states are presented in order to outline possible solutions to address Arizona's uninsured sub-populations:

- Joint state/federal programs,
- State and local initiatives, and
- Market-based reform.

Joint State/Federal Programs

Joint state/federal programs, such as Medicaid and SCHIP, cover 26% of individuals who lack private insurance coverage. These programs are administered by each state, but they must meet federal requirements regarding benefits, eligibility criteria, and other parameters. However, despite the administrative challenges, states implement these public programs because the federal government provides a match of at least 50% of the costs incurred by the state for these programs. The federal match greatly reduces the financial burden on the states to provide coverage for those individuals eligible for a public insurance program. As a result, states have widely used joint state/federal programs to cover the uninsured. Such programs include the following:

- Section 1115 eligibility expansions (Medicaid and SCHIP),
- Section 1931 eligibility coverage (Medicaid),
- Health Insurance Premium Payment (HIPP) programs (Medicaid),
- Transitional Medical Assistance (TMA) beyond the required 12 months (Medicaid),
- Eligibility Equal to or Greater than 200% of the FPL (SCHIP),
- Employer-Buy-In (SCHIP), and
- Full Cost Buy-In (SCHIP).

State and Local Initiatives

States also have the option to create entirely state-funded and state-locally funded programs to cover the uninsured, but these initiatives have not yet had a significant impact on covering the uninsured. Generally, the lack of success in attracting large portions of the uninsured through these programs is due in part to states having less funding available for such initiatives, compared to programs that have a federal funds match. However, by partnering local communities with employers, health plans, or providers, states have been moderately successful in improving access to employer-based coverage and other insurance programs for the uninsured. Such programs include the following:

- Purchasing pools,
- High-risk pools,
- Universal coverage initiatives,
- Drug benefit initiatives,
- Non-insurance approaches,
- Community initiatives, and
- Tobacco action lawsuit funded programs.

Market-Based Reform

Market-based reform strategies have had varying impacts on addressing issues with the uninsured. Some of these strategies have been successful in improving access to small employer-based coverage, either by the subsidization of small employer insurance costs, or by mandating marketplace policies. However, market-based reforms have the potential to negatively impact the marketplace as well. Mandated employer insurance and insurance rating regulations require employers and health plans to operate according to new policies that could adversely affect their financial positions or cause them to discontinue operations in the state. Strategies states have used include the following:

- Tax incentives,
- Subsidies for small employers,
- Subsidies for individuals,
- Mandated employer insurance, and
- Insurance rating regulations.

Evaluation of Success

Joint state/federal programs, state and local initiatives, and market-based reforms have varying degrees of success in addressing the needs of the uninsured. While these strategies are not always successful in meeting the needs of the uninsured as a whole, they have varying impacts on addressing the needs of targeted sub-populations.

The chart below indicates how Arizona's sub-populations and focal groups may be affected by these three strategies, based on other states' successes. Successes were determined based on the following variables:

- Does the strategy impact the uninsured sub-populations?
- Does the strategy provide sufficient enrollment and penetration rates?
- Does the strategy offer an appropriate benefit package?
- Does the strategy promote the access and use of appropriate services?
- Is the strategy affordable for the state and other stakeholders?
- Is the strategy simple for consumers and staff to administer and use?
- Does the program take advantage of available provider, employer, and other stakeholder partnerships?

Strategy	Low-Income Children and their Parents	Low-Income Hispanic Uninsured	Working Uninsured in Small Employers	Rural Low-Income Uninsured Children and their Parents
State/Federal Programs	✚	?	?	?
State and Local Initiatives	?	?	?	?
Market-Based Reforms	?	?	✚	?

✚ Highest Impact
? Moderate Impact
? Lowest Impact

The four sub-populations of Arizona's uninsured, the Low-Income Uninsured, the Ethnic Uninsured, the Working Uninsured, and the Rural Uninsured, are all differentiated statistically throughout the State. The Task Force will need to purposefully tailor initiatives to most effectively address the needs of Arizona's uninsured sub-populations.

Methodology

William M. Mercer, Incorporated (Mercer) has developed this briefing paper for the Arizona Health Care Cost Containment System (AHCCCS) as part of the Arizona State Planning Grant, which is funded by the Health Resources and Services Administration (HRSA). This paper addresses who the Arizona uninsured populations are and discusses approaches other states have used to address the needs of their uninsured. Several factors affect the uninsured, although they are not uniform across all populations. It is important to note that as key groups of the uninsured are identified, different solutions will surface for different populations throughout Arizona. This information will provide the Statewide Health Care Insurance Plan Task Force (Task Force) with the strategies that states have utilized to address their uninsured populations and how these strategies apply to Arizona's uninsured.

In addition to this paper, AHCCCS has requested the presentation of six other policy issues papers. The seven policy papers are the following:

- Identification of Sub-Populations,
- Strategies to Improve Rural Access to Health Care,
- Critique of Proposed Basic Benefit Package,
- Incentives to Increase Health Coverage,
- State High-Risk Pools,
- Purchasing Pools, and
- International Health Care Delivery Systems.

Over 150 journals, articles, and states' government sources were reviewed to provide a qualitative study that would yield diverse and reliable information on the issue of the uninsured. Electronic searches of Mercer's internal electronic research services, the Washington Resource Group (WRG) and the Information Research Center (IRC), as well as a comprehensive list of Web Sites (shown below) were utilized to obtain materials describing the uninsured.

- The Commonwealth Fund, www.cmwf.org;
- The Kaiser Family Foundation, www.kff.org;
- Medlineplus, www.medlineplus.gov;
- Employee Benefit Research Institute, www.ebri.org;
- Robert Wood Johnson Foundation, www.rwjf.org;
- National Academy for State Health Policy (NASHP), www.nashp.org; and
- State Coverage Initiatives, www.statecoverage.net.

For purposes of this paper, the focus is on those uninsured populations that were sufficiently large enough to be significantly impacted by public policy initiatives. It is important to note that specific sub-populations of the uninsured have not been discussed due to their small size or existing coverage available to them. These uninsured groups include:

- Recently, or short-term uninsured—Comprise a small percentage of the uninsured population,
- Wealthy uninsured—Not likely to be impacted by public policy initiatives,
- Immigrants—Recent immigrants and their children who lack health coverage constitute only 5% of the uninsured,
- Uninsured Native Americans—Comprise just 2% of the national uninsured population and have coverage through Indian Health Services (IHS),
- Underinsured—Individuals who currently have some form of limited coverage, but do not meet the uninsurance criteria established by the HRSA planning grant,
- Pre-Medicare uninsured, ages 50-64—Not separated into their own group due to their smaller size, but are included in the non-elderly uninsured population used throughout the paper, and
- Persons over the age of 65—Assume this population is covered by Medicare and is not a significant portion of the uninsured population.

Statistics were used referring to the non-elderly population and exclude the above uninsured populations. As well, the statistical impact of Proposition 204 has not been taken into consideration, which could reduce Arizona's uninsured by an estimated 180,000 individuals.

Faces of the Uninsured

The uninsured population is not a single, homogeneous population. It is actually comprised of a number of smaller sub-populations, formed by several key drivers of uninsurance which include:

- Age,
- Employment—status and size,
- Income—relative to poverty level,
- Ethnicity, and
- Geography—urban versus rural.

Several of these sub-populations are quite large and merit a closer look, as they will help address the factors that cause people to be uninsured in Arizona (State). Due to the lack of detailed sources of information on Arizona's uninsured sub-populations, a variety of national and Arizona-specific statistics will be used to point policy makers towards some viable solutions. The sub-populations have been identified as:

- Low-Income Uninsured (individuals or family units with incomes below 200% Federal Poverty Level (FPL)),
- Ethnic Uninsured (citizen and non-citizen non-white uninsured),
- Working Uninsured (family units with at least one full-time worker), and
- Rural Uninsured (family units not living adjacent to a Metropolitan Statistical Area (MSA)).

Focusing on these four key sub-populations presents a clear, thoughtful examination of the reasons for uninsurance and allows policy makers to craft solutions that address those reasons.

Low-Income Uninsured

In Arizona, nearly three-quarters (74%) of the uninsured reside in family units with incomes below 200% of the FPL (see Exhibit 1). In 1999, 200% of the FPL for a family of three was $26,580. This income level makes the purchase of private family health insurance for these lower-income family units largely unaffordable, while also excluding these family units from Medicaid eligibility.

Exhibit 1. Distribution of Uninsured by FPL
Ages 0–64, Arizona, 1997–1999

	Less than 200% FPL	200%+ FPL
Total Uninsured (thousands)	822	292
Percent Distribution	74%	26%

Source: Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 1998–March 2000 Current Population Surveys [1]

Age is a key driver that affects the uninsured family units with incomes less than 200% of the FPL. Examining Low-Income Uninsured by age shows a clear pattern of uninsurance used to identify the key focus within the Low-Income Uninsured Group: ***Children and their Parents***.

Key Driver

Age

Separating the Low-Income Uninsured by age provides some insight into where policy makers should focus their resources. Adults comprise nearly two-thirds (64%) of the Low-Income Uninsured while children represent the other one-third (36%) of the population. Adults also have a much higher uninsurance rate at 50%, compared to 38% for children in the Low-Income Uninsured group (see Exhibit 2).

Exhibit 2. Distribution of Low-Income Uninsured by Adults versus Children
Ages 0–64, Arizona, 1997–1999

	Children 0-18	Adults 19-64
Uninsurance Rate	38%	50%
Total Uninsured (thousands)	300 *	522
Percent Distribution	36%	64%

Source: Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 1998-March 2000 Current Population Surveys [1]

* Totals do not match due to rounding

Further examination of the Low-Income Uninsured yields a 47% uninsurance rate of parents who have a potential connection to the Medicaid program via their children (see Exhibit 3). By focusing on Low-Income Uninsured children and their parents, almost two-thirds (64%) of the Low-Income Uninsured can be addressed.

Exhibit 3. Distribution of Low-Income Uninsured by Children and their Parents
Ages 0–64, Arizona, 1997–1999

	Children 0-18	Parents	Non-Parental Adults
Uninsurance Rate	38%	47%	52%
Total Uninsured (thousands)	294 *	226	296
Percent Distribution	36%	28%	36%

Source: Commonwealth Fund Task Force on the Future of Health Insurance based on pooled March 1998-March 2000 Current Population Survey [2]

* Totals do not match due to rounding

Children have a lower rate of uninsurance primarily due to the higher FPL coverage levels available through Medicaid for children. Even with the current availability of Medicaid and the soon-to-be implemented Proposition 204 expansions, the State will not eliminate uninsurance for children below 200% of the FPL. Not every individual eligible for Medicaid presents itself at an

eligibility office and enrolls. The number of eligible people actually enrolled is known as a presentation rate. Historically, Medicaid programs have had presentation rates ranging from 70% to 80% of the total eligible population. Thus, a substantial portion of Low-Income Uninsured Arizonans have public programs available to them but are not enrolled.

Key Focus for Arizona Policy Makers

Low-Income Uninsured Children and their Parents

Based on the above data, Arizona can address a large portion of the uninsured population, specifically Low-Income Uninsured Children and their Parents, by maximizing the existing Medicaid program and the Proposition 204 expansion. It will be important to examine ways in which increasing the effectiveness of education and outreach programs will increase the penetration of existing state and federal programs, such as Medicaid, Proposition 204, and the Premium-Sharing program.

Ethnic Uninsured

Arizona has unique population demographics that need to be considered when examining the causes of uninsurance in Arizona. Of the entire Arizona population, 64% are non-Hispanic white, 25% are Hispanic, 5% are American Indian or Alaska Native, 3% are African-American, and 3% are Other [3]. Since wide disparities tend to exist in uninsurance rates among various ethnic and racial groups, examining uninsurance by ethnicity is very important to Arizona.

As a border state to Mexico, Arizona tends to have a high concentration of uninsured Hispanics. At 45% Hispanics have a much higher uninsurance rate than any other ethnic group in the State (see Exhibit 4). As they have the highest uninsurance rate among ethnic groups, the Hispanic Uninsured merits closer examination. Unfortunately, limited data is available for the uninsured Hispanic population, which makes it a much more difficult group to target.

Exhibit 4. Uninsurance Rates by Ethnicity
Ages 18–64, Arizona, 1997–1999

	Ethnicity			
	Hispanic	Non-Hispanic White	African-American	Other
Uninsurance Rate	45%	19%	23%	26%

Source: BlueCross BlueShield Association estimates based on pooled March 1998–March 2000 Current Population Surveys [4]

The disparity in uninsurance rates among the different ethnic groups is extremely significant, as it also skews the relative distribution of the uninsured in Arizona. The Hispanic population comprises only one-quarter (25%) of the Arizona population as a whole, while representing more than half (52%) of the Arizona uninsured population (see Exhibit 5) [3].

Exhibit 5. Distribution of Uninsured by Ethnicity
Ages 0–64, Arizona, 1997–1999

	Ethnicity			
	Hispanic	Non-Hispanic White	African-American	Other
Total Uninsured (thousands)	579	469	30	37
Percent Distribution	52%	42%	3%	3%

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 1998–March 2000 Current Population Surveys [5]

A key driver that affects the Hispanic uninsured is income. Examining Low-Income Uninsured by ethnic group shows a clear pattern of uninsurance used to identify the key focus within the Ethnic Uninsured: ***Low-Income Hispanic Uninsured***.

Key Driver

Low-Income

Nationally, the Low-Income Hispanic adult uninsurance rate is 53%, compared to 34% for African-Americans, and 31% for non-Hispanic whites (see Exhibit 6). This higher uninsurance rate is significant, as low-income Hispanic adults comprise only 29% of this population.

Exhibit 6. Uninsurance Rates of Low-Income Adults by Ethnicity
Ages 18–64, United States, 1997

	Ethnicity			
	Hispanic	Non-Hispanic White	African-American	Other
Uninsurance Rate	53%	31%	34%	43%
Total Uninsured (thousands)	5,100	8,700	2,800	1,000
Percent Distribution	29%	50%	16%	6%

Source: Urban Institute calculations from the 1997 National Survey of America's Families [6]

Additional Issues

A lack of detailed uninsurance data exists for the Hispanic Uninsured in Arizona. Without this detail, it is important to examine potential causes for higher uninsurance rates among the Hispanic Uninsured. Three potential causes have been identified as:

- Lack of employer-based coverage,
- Higher rate of uninsurance for non-citizens, and
- Higher percentage of two-parent households.

Lack of Employer-Based Coverage

Hispanics are much less likely than the overall population to receive employer-based coverage with a rate of 43%, compared to 71% for the non-Hispanic white population (see Exhibit 7). Employment characteristics like firm size and type of industry are strongly related to the offering of employer health benefits for Hispanics [7]. This finding is important, as Hispanics tend to work for smaller employers than do other ethnic groups, and are more likely to be employed in industries that do not offer health benefits [7].

Exhibit 7. Rates of Employer-Based Coverage by Ethnicity
Ages 0–64, United States, 1998

	Ethnicity			
	Total	Hispanic	Non-Hispanic White	African-American
Employer-Based Coverage Rate	64%	43%	71%	50%

Source: The Commonwealth Fund using the March 1999 Current Population Survey [8]

Higher Rate of Uninsurance for Non-Citizens

When examining uninsurance rates by citizenship, Hispanics who are non-citizens have an uninsurance rate of 58%, compared to a 29% uninsurance rate for Hispanics who are citizens (see Exhibit 8). This statistic is important due to Welfare reform from 1996 that restricted immigrants who have entered the United States later than 1996 from Medicaid eligibility for five years upon their arrival.

Exhibit 8. Uninsurance Rates for Citizens vs. Non-Citizens by Ethnicity
Ages 0–64, United States, 1997

	Ethnicity			
	Total	Hispanic	Non-Hispanic White	African-American
Uninsurance Rate: Citizens	16%	29%	13%	23%
Uninsurance Rate: Non-Citizens	45%	58%	25%	39%

Source: The Commonwealth Fund using the March 1999 Current Population Survey [8]

Higher Percentage of Two -Parent Households

Most Medicaid programs include eligibility criteria that include living in a single parent household, which is known as the deprivation factor. This factor is important, as nearly half (45%) of Hispanics live in two-person households, which makes them less likely to be eligible for Medicaid under traditional eligibility criteria. Arizona is addressing this issue as part of its waiver, but many eligible individuals may not know this and think they are ineligible.

Exhibit 9. Parental Status of Children Living with Parents by Ethnicity
Ages 0–64, United States, 1997

	Ethnicity		
	Hispanic	Non-Hispanic White	African-American
Two-Parent Households with income less than $20,000	45%	38%	11%

Source: U.S. Census Bureau, March 1998 [9]

Key Focus for Arizona Policy Makers

Low-Income Hispanic Uninsured

All of these characteristics point to Hispanics having less predictable sources of insurance coverage, as they are less likely to be insured via traditional insurance vehicles, such as employer-based coverage or Medicaid programs. According to the National Hispanic Medical Association, the higher Hispanic uninsurance rate is, at least, partially due to cultural differences in valuing health insurance coverage [10]. It will be important to identify culturally appropriate insurance initiatives for Hispanics to be successful at reducing the uninsurance rate for this key focal group in Arizona, the low-income Hispanic uninsured.

Working Uninsured

Arizona's economy has shifted from a focus of mining and agriculture to services, retail, and manufacturing. Arizona's shift toward service industries is similar to that of the overall United States economy. That shift, however, is most likely not the primary cause in the drop of employee coverage in Arizona. Analysis of the Current Population Survey (CPS) trends show that industry and occupation shifts account for only 30% of the decline of employer health coverage nationwide. The remaining 70% nationally is due to a broad-based drop in employer-sponsored health coverage rates in all industries [11]. Thus, Arizona's increased uninsurance rate, similar to the United States increase overall, is primarily a result of nearly all of Arizona's industries reducing employer-sponsored health coverage.

Arizona's population of family units with at least one full-time worker versus a family unit with a part-time worker or no worker presents a significant finding in the State's uninsured population. When looking at the uninsured by employment status in a family unit, data clearly shows that, although three-fourths (75%) of the uninsured have a linkage via an employee to the workplace, employer-based health care coverage is not definitively offered (see Exhibit 10).

Exhibit 10. Distribution of Uninsured by Employment Status
Ages 0–64, Arizona, 1997–2000

	At Least One Full-Time Worker	At Least One Part-Time Worker	No Worker
Total Uninsured (thousands)	830	111	173
Percent Distribution	75%	9%	16%

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 1998–March 2000 Current Population Surveys [5]

Although employment status is a significant finding, a key driver that affects the Working Uninsured is employer size. Employer size is determined by the number of employees. This paper defines small employers as 0–99 employees, large employers as 100–499 employees, and very large employers as over 500 employees. Examining the Working Uninsured by employer size shows a clear pattern of uninsurance used to identify the key focus within the Working Uninsured Group: ***Working Uninsured in Small Employers***.

Key Driver

Employer Size

Statistics show that the size of an employer affects the likelihood that employees will be uninsured, as small firms are less likely to offer coverage than larger firms [12]. It is important to note, then, that 97% of Arizona employers consist of fewer than 100 employees, compared to the national average of 41%, thus, impacting the number of uninsured workers in Arizona (see Exhibit 11).

Exhibit 11. Size of Employers
All Firm Sizes, Arizona, Third Quarter 1999

	Employer Size					
	0-49	50-99	100-249	250-499	500-999	1,000+
Total Number of Firms (thousands)	104.33	3.28	2.17	.63	.28	.17
Percent Distribution	94%	3%	2%	.6%	.2%	.2%

Source: Arizona Department of Economic Security updated March 20, 2000 [13]

As noted above, 97% of Arizona's employers consist of fewer than 100 employees compared to a national average of 41%. This statistic shows that Arizona's economy is dominated by employers who are the least likely to offer insurance and the most likely to have higher than average uninsurance rates. That is borne out below, as the smallest Arizona employers, with less than 10 employees, have the highest uninsurance rate at 45% (see Exhibit 12).

Exhibit 12. Uninsurance Rates by Firm Size
Ages 18–64, Arizona, 1997–1999

	Firm Size					
	<10	10–24	25–99	100–499	500–999	1,000+
Uninsurance Rate	45%	35%	34%	25%	23%	19%

Source: BlueCross BlueShield Association based on pooled March 1998–March 2000 Current Population Surveys [4]

Key Focus for Arizona Policy Makers

Working Uninsured in Small Employers

Upon review of these statistics for the Working Uninsured in Arizona, programs focusing on the Working Uninsured will need to consider employer size. This issue of employer size and uninsurance is important to Arizona, as the economy is dominated by small employers. The smaller an employer, the less likely they are to provide health insurance and the more likely they are to have higher than average uninsurance rates. Within in the Working Uninsured, it is important to examine ways to increase the percentage of small employers offering health insurance and the number of employees taking this insurance coverage.

Rural Uninsured

To place rural uninsurance in perspective nationally, among the 42 million uninsured in the United States, almost 20% live in rural areas. Their health care needs differ from that of the rest of the country because the rural population as a whole is older, poorer, has fewer transportation options, and is less healthy compared to people in urban areas. Nearly 8 million people living in rural areas, or 18% of the non-elderly rural population, were uninsured in 1999 [14]. The type of health insurance coverage, when stratified by proximity to a MSA is demonstrated in Exhibit 13 below. MSA (1990 Standard) is defined as one city with 50,000 or more inhabitants, or as defined by the U.S. Census Bureau, an urbanized area of at least 50,000 inhabitants and a total metropolitan population of at least 100,000 [15].

Exhibit 13. Distribution of Insurance Coverage by Community Type
Ages 0–64, United States, 1997

	Non-Adjacent to MSA	Adjacent to MSA	MSA
Uninsurance Rate	22%	18%	14%
Employer-Based Coverage	55%	66%	70%

Source: Urban Institute Report, May 2000 [16]

Thus, individuals living in rural areas have a much higher rate of uninsurance, and this rate increases the farther an individual lives from an urban area. Therefore, studying the causes of rural uninsurance will give the Task Force insight into the resulting sub-populations of the Rural Uninsured and how to better address their needs. The Rural Health Office, as part of Arizona's HRSA grant process, will be taking a closer look at actual uninsurance rates by county. As well,

the second Mercer briefing paper, titled "Initiatives to Improve Access to Rural Health Care Services," will examine in detail employment factors of the Rural Uninsured, provider network inadequacies, and rural demographics. For purposes of this paper, Mercer will discuss how rural demographics form a sub-population of the uninsured by showing national demographics for this sub-population.

Two key factors that affect the Rural Uninsured are income and age. Examining Rural Uninsured by income and age shows a clear pattern of uninsurance used to identify the key focus within the Rural Uninsured Group: ***Rural Low-Income Uninsured Children and their Parents.***

Key Drivers

Income Relative to the FPL

Two-thirds (67%) of the uninsured in rural areas have family incomes of less than 200% of the FPL (see Exhibit 14). As noted previously, in the Low-Income Uninsured discussion, even with the availability of Medicaid programs and the soon-to-be implemented Proposition 204 expansion, not all of these Rural Low-Income Uninsured enroll in available public programs.

Exhibit 14. Distribution of Rural Uninsured by Income
Ages 0–64, United States, 1999

	Less than 200% FPL	200% + FPL
Total Uninsured (thousands)	5,226	2,574
Percent Distribution	67%	33%

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000 Current Population Surveys [5]

Age

Of these Rural Low-Income Uninsured, adults comprise a majority (70%) of the population, while children represent only one-third (30%) of the Rural Low-Income Uninsured population (see Exhibit 15).

Exhibit 15. Distribution of Rural Low-Income Uninsured by Age
Ages 0–64, United States, 1999

	Children 0-18	Adults 19-64
Total Uninsured (thousands)	1,560	3,666
Percent Distribution of Low-Income	30%	70%

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000 Current Population Surveys [5]

Further examination of the Low-Income Uninsured in rural areas shows that approximately two-thirds (64%) of the Rural Low-Income Uninsured have a potential connection to the Medicaid program via their children (see Exhibit 16). By focusing on the Rural Low-Income Uninsured Children and their Parents, nearly two-thirds (64%) of the Rural Low-Income Uninsured can be addressed.

Exhibit 16. Distribution of Rural Low-Income Uninsured by Children and their Parents
Ages 0–64, United States, 1999

	Children 0-18	Parents	Non-Parental Adults
Total Uninsured (thousands)	1,560	1,794	1,872
Percent Distribution of Rural Low-Income	30%	34%	36%

Sources: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on pooled March 2000 Current Population Surveys [5]

For a more detailed discussion on the issue of rural health access and rural uninsurance, see Mercer's briefing paper completed for the Task Force titled "Initiatives to Improve Access to Rural Health Care Services."

Key Focus for Arizona Policy Makers

Rural Low-Income Uninsured Children and their Parents

National rural demographics, such as income and age, present findings that show how being in a rural area as opposed to an urban area contribute to higher uninsurance rates of rural populations. A major segment of the Rural Uninsured can be addressed by focusing on Rural Low-Income Uninsured Children and their Parents and, as mentioned previously, finding innovative and creative ways to maximize their participation in Medicaid and other available public programs.

Strategies

Within each state's unique mix of uninsured sub-populations, there are corresponding barriers to health insurance. States have implemented a variety of strategies in an effort to remove barriers for targeted uninsured sub-populations. These strategies have been used by states to meet the needs of the uninsured, either by expanding access to services, containing costs, or other various means. The specific state and local strategies cited are referenced to illustrate some of the successes and challenges associated with each particular strategy.

The strategies have been grouped into the following categories:

- Joint state/federal programs,
- State and local initiatives, and
- Market-based reform.

Each of the following variables will be considered to determine the successes and challenges of these state strategies:

- Does the strategy impact the uninsured sub-populations?
- Does the strategy provide sufficient enrollment and penetration rates?
- Does the strategy offer an appropriate benefit package?
- Does the strategy promote the access and use of appropriate services?
- Is the strategy affordable for the state and other stakeholders?
- Is the strategy simple for consumers and staff to administer and use?
- Does the program take advantage of available partnerships?

State/Federal Programs

The Center for Medicare and Medicaid Services (CMS) (formerly known as the Health Care Financing Administration or HCFA) oversees two major public insurance programs for the non-elderly uninsured, Medicaid, and the State Children's Health Insurance Program (SCHIP). These programs are administered by each state, but they must meet federal requirements regarding benefits, eligibility criteria, and other parameters. Despite these challenges, states implement public programs because the federal government provides a match of at least 50% of the costs incurred by the state for the programs. This federal funds "match" is currently even higher for the SCHIP program (between 65% and 85%), given the priority the federal government has placed on providing health insurance to uninsured children. The federal match greatly reduces the financial burden on the states to provide coverage for those individuals eligible for a public insurance program. As a result, states have widely used joint state/federal programs to cover the uninsured. Twenty-six percent of Arizonans who lack private insurance are covered by Medicaid or SCHIP [1]. If states were to increase their Medicaid penetration rates, the uninsurance rate would be reduced by a corresponding amount.

Medicaid

Medicaid eligibility was originally aimed at uninsured children, pregnant women, and the disabled/chronically ill. Welfare reform and other federal acts of the late 1980s and 1990s have expanded coverage to uninsured parents and other low-income adults. The following strategies have been implemented by states interested in expanding enrollment by reducing or eliminating Medicaid enrollment and eligibility barriers:

Section 1115 Eligibility Expansions	Section 1115 of the Social Security Act allows states to apply for a waiver of certain Medicaid requirements, including particular eligibility requirements, the scope of services available, and the freedom to choose a provider. Section 1115 programs have been successful from the vantage point that enrollment has been expanded to include large numbers of uninsured families with state financing at no more than half of the cost. Some states are examining waivers to add adults without children to the Medicaid and SCHIP programs.
Section 1931 Eligibility Coverage	Section 1931of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) severed the longstanding relationship between welfare and Medicaid. Section 1931 gives states the flexibility to make eligibility rules less restrictive, with the ability to elect to increase income thresholds, to increase or even eliminate resource limits, and to expand coverage to low-income, two-parent working families, all without the constraints of an 1115 waiver. Section 1931 programs have been successful in gaining enrollment results similar to those of an 1115 waiver, but without the hassle of a waiver application process. Approximately 30 states have utilized the Section 1931 provisions, including Arizona [17]. However, policy makers should be concerned with a substitution phenomenon known as crowd-out. Crowd-out is defined as individuals moving from private insurance to public insurance programs like Medicaid. A further discussion outside the scope of this paper is necessary to determine whether it is realistic or appropriate to attempt to avoid all forms of crowd-out. Rhode Island's Rite Care program and the issues they have faced with Section 1931 and the crowd-out phenomenon is discussed at the end of this section.
Health Insurance Premium Payment (HIPP) Programs	Section 1906 of the Social Security Act requires states to pay premiums, deductibles, and coinsurance of employer-sponsored plans on behalf of Medicaid recipients when it is cost-effective to do so. HIPP programs have not enrolled adequate numbers of eligible individuals and are generally very complex to administer [18]. Also, most states use HIPP programs as initiatives to save money, not to increase enrollment.

Transitional Medicaid Assistance (TMA) Beyond the Required 12 Months	TMA requires states, through the year 2001, to extend Medicaid coverage for up to 12 months to families who lose their eligibility due to increased earnings. Extending TMA beyond the required 12 months helps to ensure that former welfare recipients have health care coverage for an adequate period of time after entering the workforce. TMA programs have been unsuccessful as well due to the time-limited nature and burdensome reporting requirements, which have led to its under-utilization [19].

State Children's Health Insurance Program (SCHIP)

SCHIP differs from Medicaid programs in that SCHIP programs receive an enhanced federal match (i.e., higher than the federal match provided to states for their Medicaid programs), and SCHIP eligibility was originally limited to low-income children. The federal government has begun to allow states more flexibility in expanding their programs to children at higher income levels, as well as expanding coverage to parents. Many states have taken advantage of the SCHIP enhanced federal match, implementing the following strategies:

Eligibility Equal to or Greater than 200% of the FPL	The majority of states provide SCHIP eligibility up to or greater than 200% of the FPL. States have implemented several models to cover children above 200% of the FPL. With the flexibility to disregard portions of income, some states such as Connecticut have been able to effectively raise the income limit to 300% of the FPL. Expanding eligibility up to or beyond 200% of the FPL has been successful by taking advantage of enhanced federal funding and expanding coverage beyond low-income families, allowing states to reach uninsured in numbers that other public programs have not been able to insure in the past.
Employer-Buy-In	Similar to HIPP programs under Medicaid, states have the option to request federal approval to operate an employer-buy-in program under SCHIP. The program must meet SCHIP requirements, including minimum employer premium contribution levels, enrollee cost-sharing limits, and benefit standards. States must show that purchasing employer coverage is cost-effective as compared to covering the child under SCHIP. Massachusetts is one such state that was successful in gaining federal approval to subsidize employer-based coverage in instances where the employer only contributes 50% of the premium, as compared to the typical 60% generally required under SCHIP. Massachusetts' case study is discussed at the end of this section.

Section 1115 Waiver Programs	In late 2000, CMS provided guidance to states on which SCHIP provisions could be waived. Already, seven states have submitted SCHIP 1115 waiver requests to CMS. States are using SCHIP Section 1115 waivers to expand coverage to adults, with support from CMS. Several reports suggest that by providing health insurance to parents, states are more likely able to insure a greater number of children. States have only recently applied to expand coverage for adults using Section 1115 waiver programs and do not yet have statistics on the success of this program. Some states are examining waivers to add adults without children to the Medicaid and SCHIP programs.
Full Cost Buy-In	Some states have opted to allow higher-income families to purchase coverage for their children through SCHIP at the full premium price, (i.e., at no state subsidy). These higher income families generally have access to the same benefits and health plans as SCHIP-eligible children, but pay full cost of the premium and may have cost-sharing. Enrollment in buy-in programs has been low, with states such as Connecticut enrolling approximately 3% of the SCHIP-eligible uninsured in their full cost buy-in program.

Variables

- Impacts the Uninsured Sub-Populations—Policy makers in the past have directed Medicaid and SCHIP eligibility requirements toward broad uninsured sub-populations, especially the low-income. States now have additional flexibility to target additional uninsured sub-populations with waivers and other strategies. However, due to the complexity of federal regulations, these initiatives still focus on the Low-Income Uninsured sub-population, limiting the success on impacting other sub-populations.
- Provides Sufficient Enrollment and Penetration Rates—States have had moderate to high success with their penetration ratios (i.e., the percentage of the targeted uninsured that enroll in the program). However, eligible individuals are failing to enroll because they perceive a stigma with public insurance programs, place a low value on the benefit package, or are wary of the application process and other paper work. Additionally, uninsured parents are failing to apply for coverage for their uninsured children. Yet despite these challenges, state/federal programs are more successful at enrolling sufficient numbers of uninsured individuals than other strategies.
- Offers an Appropriate Benefit Package—State Medicaid and SCHIP programs have been successful in providing an extensive benefit package that generally includes services that are not always included in private insurance benefit packages. These additional services include well-care; Early, Periodic Screening, Diagnosis and Treatment (EPSDT); prescription drugs; comprehensive pregnancy and delivery; and non-emergent transportation.

- Promotes the Access and Use of Appropriate Services—Many states have implemented managed care programs for their Medicaid and SCHIP programs. This change has successfully improved both access to care and utilization of appropriate health services, although Medicaid and SCHIP enrollees are still more likely to use services inappropriately than privately insured individuals.
- Is Affordable for All Stakeholders—The federal funds match has been the driving force for states to implement joint state/federal programs. States are more likely to provide coverage knowing that the federal government will provide a match, or in the case of SCHIP programs, an enhanced match. Given that these programs are provided at a low cost or no cost to the covered individuals, they have been successful in meeting the needs of the uninsured. As well, due to the federal match, these programs have been affordable for states and other stakeholders.
- Is Simple to Administer and Use—Almost all of the joint state/federal programs are complex to administer. Waiver application processes, cost-effectiveness requirements, and differing eligibility requirements between the Medicaid and SCHIP programs are among the challenges that make these programs difficult to implement and administer. Some strategies, such as employer-buy-in programs, have had very little success given the complex process involved in creating a seamless program based upon providing Medicaid or SCHIP benefits and cost-sharing through a private insurance plan. Wisconsin's BadgerCare program is an unusual example of a simple and accessible program, with seamless integration of SCHIP and Medicaid. SCHIP and Medicaid have the same benefits, same application and eligibility process, same health plans, and low-income families can purchase coverage if they lose eligibility [20].
- Takes Advantage of Available Partnerships—Medicaid and SCHIP programs were not legislated to successfully take advantage of available partnership opportunities. These programs generally do not take advantage of grants offered by non-profit organizations or partnerships with other public or private organizations to cover the uninsured. These programs also do not have a high success rate with providing employer coverage to the uninsured.

Exhibit 18. Evaluation of Success of Joint State/Federal Programs

Evaluation Criteria		Minimal Success	Moderate Success	Successful
Impacts the Uninsured Sub-Populations:	Low-Income			✓
	Ethnic		✓	
	Working	✓		
	Rural		✓	
Provides Sufficient Enrollment and Penetration Rates				✓
Offers an Appropriate Benefit Package				✓
Promotes the Access and Use of Appropriate Services				✓
Is Affordable for All Stakeholders				✓
Is Simple to Administer and Use		✓		
Takes Advantage of Available Partnerships		✓		

Source: Mercer's evaluation of states' strategies to provide insurance to the uninsured, 2001

Case Study

Medicaid

Rhode Island extended Medicaid coverage for their original 1115 waiver, the RIte Care program, using a Section 1931 strategy. Targeted toward uninsured low-income families, this program expanded eligibility to all low-income families to 185% of the FPL and eliminated resource limit testing. Thirteen thousand new members enrolled in the program in 1999. However, Rhode Island found that one-third of their new RIte Care members in 1999 had switched from a commercial product. This substitution phenomena of individuals moving from private insurance to public insurance programs like Medicaid is called crowd-out. While commercial rates have risen, Rhode Island also believes the crowd-out occurred because RIte Care offers a generous package of benefits, minimal cost-sharing, and no waiting [21]. Rhode Island applied to implement waiting periods and additional cost-sharing to curb crowd-out, but CMS was opposed. In 2000, the State then applied for a premium assistance program and a SCHIP family coverage waiver to deter this problem.

SCHIP

Massachusetts is one of approximately six states that has been given approval to implement a SCHIP employer-buy-in strategy. After two years, the program has approximately 7,000 individuals, although the majority are subsidized with Medicaid dollars, due in part because SCHIP subsidization is more complex. Massachusetts was successful in gaining federal approval to subsidize employer coverage in instances where the employer only contributes 50% of the premium, as compared to the typical 60% generally required under SCHIP. Two states, Maryland and New Jersey, are in the process of implementing employer-buy-in programs. However, three of the states with approval to implement programs, Mississippi, Oregon, and Wisconsin, have had very limited success. These states cite strict federal requirements and the lack of consistency between SCHIP and employer-coverage as major reasons for their lack of success, as these factors reduce the chance of cost-effectiveness and make implementation complex [22].

State and Local Initiatives

States have the option to create entirely state-funded and state-locally funded programs to cover the uninsured, providing states the freedom and flexibility in the design of these programs. However, state- and state-locally funded programs have not had a significant impact on covering the uninsured, as states generally have less funding available for these programs than for programs that have a federal funds match. Yet, state and local programs have the ability to fill in "gaps" left by existing programs and insurance market conditions. By involving local communities, employers, health plans, or providers, states have been successful in taking advantage of partnerships in designing and implementing programs to meet the needs of more targeted uninsured sub-populations. The following outlines strategies used by states interested in implementing unique programs to meet the needs of targeted statewide or local uninsured sub-populations:

Purchasing Pools	Purchasing pools are insurance purchasing and administration programs for a collective group, offering the advantages of group insurance to small employers and individuals. Approximately 20 purchasing pools exist, covering approximately 1 million individuals, with most pools covering fewer than 50 thousand individuals [23]. Purchasing pools are established with state and/or non-profit organization "seed money" and generally receive on-going operational, marketing, and/or premium funding. Many of the state-run pools have failed, in large part due to hostility from health plans and agents, as well as adverse risk selection. Adverse risk selection refers to programs receiving a disproportionate share of high health risk individuals. For example, the success of New Mexico's purchasing pool has been threatened by exposure to adverse risk selection. Health plans prefer exclusive contracts with employer groups, while agents fear loss of commissions [24]. Unfortunately, purchasing pools have not had sufficient enrollment to have as significant an impact on the uninsured as state/federal programs. According to one study, even if purchasing pools were more successful in lowering prices, subsidies would have to equal between one-third and one-half of the premium in order to produce a substantial reduction in the number of uninsured [25].
High-risk Pools	A high-risk pool is typically a state-created, non-profit association that offers health insurance to individuals with pre-existing health problems or people who have been denied coverage in the private market due to a chronic illness or condition. High-risk pools are generally subsidized through assessments on insurers or through state appropriations. States generally put caps on premiums in their high-risk pools. High-risk pools are costly and policy makers struggle with approaches to fund the programs, whether through state appropriations, health plan assessments, or other funding mechanisms [26].
Universal Coverage Initiatives	Some states, including Massachusetts, have considered petitions and legislation to provide universal health coverage to all residents. The initiatives generally are based upon offering basic health benefits, with a sliding fee scale (i.e., insurance at no cost for the very poor), increasing incrementally to full cost for those who are financially secure. The success of Massachusetts' petition was thwarted by its own sponsors when they realized a managed care reform bill currently under consideration by the legislature would meet many of their needs without the delays built into the petition [21].

Drug Benefit Initiatives	Several states have recently focused their health care legislation on prescription drug coverage for those who lack this coverage. Maine enacted a law requiring the State to serve as a pharmacy benefit manager (PBM) for residents without prescription drug benefits. Another 20 states have implemented related initiatives to provide prescription drug assistance to seniors, disabled, and low-income individuals [21]. The majority of initiatives have focused on coverage for the elderly population. Due to higher prescription drug utilization needs, the elderly are at greater risk of being unable to afford private coverage.
Non-Insurance Approaches	Some states, including Connecticut, have implemented prescription drug discount programs for the uninsured. States use this approach to encourage individuals lacking coverage to purchase drugs for the prevention and treatment of health problems. Subsidizing provider costs has a similar outcome to discount programs. Many rural counties have leveraged grants to subsidize costs of their rural hospitals and health clinics, affording reasonable general services, specialty services, and even pharmacy services at a "one-stop shopping" clinic. This approach is addressed in the briefing paper "Initiatives to Improve Access to Rural Health Care Services." It is difficult to determine whether provider subsidization and discount programs actually improve access or just change the funding mechanism by replacing some charity care with discounted care.

Community Initiatives	Successful health insurance initiatives have been implemented in some communities. These initiatives are generally either health insurance programs for small business employees or no-cost/ low-cost health insurance programs providing limited benefits for the Low-Income Uninsured. They are designed to reduce the number of Working Uninsured and hospital charity care. Several cities, including Boston, Indianapolis, and Lansing, all have community no-cost health insurance initiatives for the Low-Income Uninsured. The programs were developed at either the state or local level, generally partially funded with grants, and were intended to serve low-income uninsured individuals who are ineligible for Medicaid and SCHIP by providing limited benefits at no cost or low cost. Most of these programs were developed to reduce the anticipated financial strain that Medicaid managed care would place on safety net providers by implementing programs to reduce charity care (i.e., the usage of emergency room and inpatient services by the otherwise uninsured) [27]. Other local initiatives, such as San Diego's FOCUS program, a health insurance initiative providing low-cost coverage to low-income uninsured workers, have had only moderate successes. Although the FOCUS program was initially successful in negotiating low provider rates and no broker commission, their future success will be limited due to their inability to replicate the low provider rates while maintaining affordable coverage [18].
Tobacco Action Lawsuit Funded Programs	States have begun to use tobacco action lawsuit dollars to fund state, local, and state/federal programs. A $206 billion Master Settlement Agreement was signed between the country's four largest tobacco companies and 46 states. This tobacco settlement provides an unprecedented opportunity for coverage expansions. The majority of states, including Arizona, have decided to use these funds for health-related programs. However, some of these states are using their funds for Medicaid and SCHIP expansion programs rather than state and local initiatives in order to take advantage of federal matching funds [21].

Variables

- Impacts the Uninsured Sub-Populations—Purchasing pools have been moderately successful in targeting the Working Uninsured. Small employers may already have private insurance, buying into the pool simply as a cost-savings decision. In general, state and local initiatives have the ability to be more focused than joint state/federal programs in utilizing geographic and employment eligibility standards to target the Rural and Ethnic Uninsured sub-populations.
- Provides Sufficient Enrollment and Penetration Rates—Local initiatives, high-risk pools, and purchasing pools generally have not been successful in enrolling large numbers of enrollees. However, a universal coverage strategy could expect high enrollment.

- Offers an Appropriate Benefit Package—Local initiatives, high-risk pools, and purchasing pools frequently have typical private insurance benefit packages. In some instances, purchasing pool administrators are challenged to reduce benefits in order to make the program more affordable to small business employers, targeting their pool toward those small employers who are unable to afford health insurance for their employees.
- Promotes the Access and Use of Appropriate Services—Purchasing pools generally offer their clients the option of choosing among several health plans. Local initiatives may have limited provider participation if the program has insufficient funding, as discussed above. In general, these programs have been successful in providing enrollees access to and appropriate use of services.
- Is Affordable for All Stakeholders—Small employers frequently do not participate in purchasing pools. While part of this challenge is due to the lack of partnering between the pools, health plans, and insurance agents, many small employers cannot afford to purchase insurance unless it is heavily subsidized. High-risk pools provide the most affordable insurance option for the chronically ill, at the expense of the healthy.
- Is Simple to Administer and Use—Purchasing pools are managed by teams with professional purchasing expertise. This expertise combined with the pool's pre-determined goals and level of benefits removes the need for employers to comparison shop.
- Takes Advantage of Available Partnerships—Purchasing pools frequently fail because of their inability to partner with key stakeholders. As mentioned above, health plans and insurance agents frequently refuse to partner with purchasing pools. Local initiatives, on the other hand, are quite successful in attracting funding from non-profit, community, and health-based organizations. Local initiatives are typically managed by a diverse group of community and health care stakeholders.

Exhibit 19. Evaluation of Success of State and Local Initiatives

Evaluation Criteria		Minimal Success	Moderate Success	Successful
Impacts the Uninsured Sub-Populations:	Low-Income	✓		
	Ethnic		✓	
	Working		✓	
	Rural		✓	
Provides Sufficient Enrollment and Penetration Rates		✓		
Offers an Appropriate Benefit Package			✓	
Promotes the Access and Use of Appropriate Services				✓
Is Affordable for All Stakeholders			✓	
Is Simple to Administer and Use			✓	
Takes Advantage of Available Partnerships			✓	

Source: Mercer's evaluation of states' strategies to provide insurance to the uninsured, 2001

Case Study

Purchasing Pools

New Mexico's Health Insurance Alliance (NMHIA) is a quasi-public, non-profit purchasing pool established in 1994 to provide health insurance to small businesses with 2 to 50 eligible employees, the self-employed, and individuals that lose their group coverage. Approximately 7,800 individuals were insured through the NMHIA as of August 2000 [28]. Like other purchasing pools, NMHIA's success has been threatened by exposure to adverse risk selection (i.e., becoming a dumping ground for high health risk individuals). Purchasing pools' exposure to adverse risk selection is often referred to as the "assessment spiral" or "death spiral." This spiral refers to a potential phenomenon of pools experiencing adverse risk selection, which in turn, necessitates increases in premiums and possibly assessments. The upward spiral of risk and cost continues, as the healthiest individuals seek more reasonable coverage options and the pool, in effect, becomes a high-risk pool. NMHIA is concerned that such a spiral may occur, as the pool attracts individuals who have lost coverage and some employers use the pool to enroll their higher-risk employees [18].

Market-Based Reform

States have found that controls placed on the health care marketplace can sometimes have a positive impact on meeting the needs of the uninsured. These controls can be in several varying forms, each designed to eliminate or reduce problems with access, affordability, or benefits. The following marketplace reform strategies have been used by states to address the needs of the uninsured:

Tax Incentives	As discussed earlier, employees that work for a small business frequently do not have access to insurance through their employer. The goal of states (such as Kansas) that implement a tax incentive strategy is to provide a temporary incentive to encourage small businesses to begin providing health insurance to their employees. Kansas offers a tax credit to small employers who begin to offer health coverage for their employees. As it currently exists, the credit is $35 per month per employee or 50% of the annual premium, whichever is less, for the first two years. The credit decreases over the next three years until the sixth year, in which no credit is available [28].
Subsidies for Small Employers	Small employer subsidies are designed to provide financial support to small businesses in providing insurance for their employees. A policy decision must be made as to whether the subsidy is only for firms newly offering coverage or if the subsidy is for all firms, including those firms that currently are offering coverage to their employees. States pay a portion of the cost of providing insurance to their employees. States sometimes expand these programs to offer coverage to self-employed and other targeted employer-related uninsured sub-populations. State subsidies provide an

	infusion of funding, having a positive impact on the marketplace. CMS is currently considering providing a federal match for Massachusetts' subsidies program, but first wants to confirm that crowd-out is not occurring, as this program does not have a look-back period. A look-back period refers to not requiring workers to be uninsured for a certain period of time or for employers to be offering coverage for the first time in order to be eligible for the subsidization. The use of this program in Massachusetts is discussed in a case study at the end of this section.
Subsidies for Individuals	Individual subsidies are designed to provide continuous financial support to individuals for the purchasing of health insurance. States pay a portion of the cost of the coverage, in an effort to make health insurance affordable to the targeted low-income, small business, and other individuals that otherwise would not be able to afford purchasing insurance.
Mandated Employer Insurance	Hawaii is one of the most aggressive states in its approach to ensuring its residents have access to reasonable private insurance. For decades, Hawaii has mandated that employers offer, and help pay for, health insurance for full-time workers. This approach is more feasible for a geographically isolated state, such as Hawaii. States are typically surrounded by neighboring states, and could experience migration of businesses, especially small businesses, in reaction to this type of mandate. States (such as Massachusetts and Washington) had enacted similar employer coverage mandates, but repealed the mandates before they went into effect in the face of pressure from small businesses that anticipated the new policies would adversely affect their financial position.
Insurance Rating Regulations	Several states impose regulations on health plans related to selling health insurance. States limit the premiums that can be charged to high health risk individuals, in order to ensure that these individuals can afford to purchase coverage. These regulations can be in the form of rate bands or community rating, both of which limit the ability of insurers to match pricing to health risk. Some states also require insurers to offer standardized benefit packages, making it easier for individuals to comparison shop.

Variables

- Impacts the Uninsured Sub-Populations—Tax incentives have been targeted at uninsured small employers and employees. Success has been limited because the uninsured need immediate relief and typically cannot afford the initial out-of-pocket expense while waiting for the tax incentive. Subsidies and mandated employer insurance can be used to target both insured and uninsured workers. Direct subsidies at least partially address the timing delays that tax incentives create. Mandated Employer Insurance is typically met with stiff resistance from the business community due to the associated costs.

- Provides Sufficient Enrollment and Penetration Rates—Hawaii's mandated employer insurance strategy was successful in enrolling large numbers of uninsured individuals. However, the other strategies generally have only enrolled a small portion of the uninsured, with strategies only focusing on insuring small business employees or the chronically ill. Yet, as is the case in Arizona, a large portion of the uninsured work for small employers.
- Offers an Appropriate Benefit Package—All of the strategies have been successful at providing standard private insurance benefit packages.
- Promotes the Access and Use of Appropriate Services—The majority of the strategies have been successful in allowing individuals to purchase private insurance through their employers, indicating an easy application process and existing guidelines to ensure the appropriate use of services.
- Is Affordable for All Stakeholders—Tax incentives initially help to make insurance affordable for small businesses, but these incentives are temporary and employers are then required to evaluate whether they can afford to continue providing insurance in the future. Subsidies successfully help make insurance affordable for small businesses in the long term, but at a substantially higher cost to the state. Mandated employer insurance is not affordable for some businesses. Insurance rating regulations should not have a negative impact on health plans, but will make coverage affordable to the chronically ill by placing the financial burden on the healthy.
- Is Simple to Administer and Use—Insurance rating regulations and mandated employer insurance are easier strategies for states to implement and maintain. Tax incentives and subsidies are more challenging to design, implement, and administer, both from a state and employer prospective.
- Takes Advantage of Available Partnerships—Tax incentives and employer subsidies successfully foster partnerships between states and employers, with the states assisting small employers with providing insurance to their employees. However, insurance rating regulations and mandated employer insurance are hindrances to partnerships, relying instead on the authority of the state's executive power.

Exhibit 20. Evaluation of Success of Market-Based Reform

Evaluation Criteria		Minimal Success	Moderate Success	Successful
Impacts the Uninsured Sub-Populations:	Low-Income		✓	
	Ethnic		✓	
	Working			✓
	Rural	✓		
Provides Sufficient Enrollment and Penetration Rates			✓	
Offers an Appropriate Benefit Package				✓
Promotes the Access and Use of Appropriate Services				✓
Is Affordable for All Stakeholders			✓	
Is Simple to Administer and Use			✓	
Takes Advantage of Available Partnerships			✓	

Source: Mercer's evaluation of states' strategies to provide insurance to the uninsured, 2001

Case Study

Subsidies for Small Employers

Massachusetts began providing subsidies for small employers in 1999 under the Insurance Partnership (IP) component of the MassHealth Family Assistance program. IP offers subsidies to small businesses of up to 50 full-time employees to help pay for health insurance premiums for low-wage workers and to low-income, self-employed individuals. CMS is considering providing a federal match for the program, but first wants to confirm that crowd-out is not occurring. This concern is reasonable, as IP does not have a look-back period. A look-back period refers to not requiring workers to be uninsured for a certain period of time or for employers to be offering coverage for the first time in order to be eligible for the subsidization [18].

Evaluation of Success

Joint state/federal programs, state and local initiatives, and market-based reforms have varying degrees of success in addressing the needs of the uninsured. While these strategies are not always successful in meeting the needs of the uninsured as a whole, they have varying impacts on addressing the needs of targeted sub-populations. The chart below indicates how the targeted sub-populations are affected by these three strategies.

Strategy	Low-Income Children and their Parents	Low-Income Hispanic Uninsured	Working Uninsured in Small Employers	Rural Low-Income Uninsured Children and their Parents
State/Federal Programs	✚	?	?	?
State and Local Initiatives	?	?	?	?
Market-Based Reforms	?	?	✚	?

✚ Highest Impact
? Moderate Impact
? Lowest Impact

As discussed in this briefing paper, the four sub-populations of Arizona's uninsured, the Low-Income Uninsured, the Ethnic Uninsured, the Working Uninsured, and the Rural Uninsured, are all differentiated statistically throughout the State. It will be important to purposefully tailor initiatives to most effectively address the needs of Arizona's uninsured sub-populations.

Reference Guide

[1] Hoffman, C., & Pohl, M. (2000). Health Insurance Coverage in America: 1999 Data Update. Washington D.C.: The Kaiser Commission on Medicaid and the Uninsured.

[2] Glied, S.A. (2000). Challenges and Options for Increasing the Number of Americans with Health Insurance. New York: The Commonwealth Fund Task Force on the Future of Health Insurance.

[3] U.S. Census Bureau. (2000). Profile of General Demographic Characteristics for Arizona: 2000. Retrieved from U.S. Census Bureau on the World Wide Web: http://www.census.gov/Press-Release/www/2001/tables/redist_az.html#demoprofile.

[4] Blue Cross Blue Shield Association. (2000). The Uninsured in America: A State-By-State Comparison. Washington D.C.: Author.

[5] The Kaiser Commission on Medicaid and the Uninsured. (1998). State Health Facts. Washington D.C.: Author. Retrieved from Kaiser Commission on Medicaid and the Uninsured: http://www.statehealthfacts.kff.org.

[6] Holahan, J., & Brennan, N. (2000). Who are the Adult Uninsured? (Series B, No. B-14). Washington D.C.: The Urban Institute.

[7] Schur, C.L., Feldman, J. (2001). Running in Place: How Job Characteristics, Immigrant Status, and Family Structure Keep Hispanics Uninsured. New York: The Commonwealth Fund.

[8] Quinn, K. (2000). Working Without Benefits: The Health Insurance Crisis Confronting Hispanic Americans. New York: The Commonwealth Fund.

[9] U.S. Census Bureau. Living Arrangements of Children Under 18 Years, by Marital Status and Selected Characteristics of Parents: March 1998. Retrieved on February 7, 2000, from U.S. Census Bureau on the World Wide Web: http://www.census.gov.

[10] National Alliance for Hispanic Health. (2001). A Primer for Cultural Proficiency: Towards Quality Health Services for Hispanics. Retrieved from National Alliance for Hispanic Health on the World Wide Web: http://www.hispanichealth.org.

[11] Medoff, J.L., Shapiro, H.B., Calabrese,, M., & Harless, A.D. (2001). How the New Labor Market is Squeezing Workforce Health Benefits. New York: The Commonwealth Fund, Center for National Policy.

[12] Employee Benefit Research Institute. (2000). Small Employer Health Benefits Survey. Washington D.C.: Author.

[13] Arizona Department of Economic Security Population Statistics Unit. (2000). Phoenix: Arizona Department of Economic Security.

[14] The Kaiser Commission on Medicaid and the Uninsured. (2001). The Uninsured in Rural America. Washington D.C.: Author.

[15] U.S. Census Bureau. (2001). http://www.census.gov.

[16] Ormond, B.A., Zuckerman, S., & Lhila A. (2000). Rural/Urban Differences in Health Care are Not Uniform Across States. New Federalism, B (B-11), 1–5.

[17] The Robert Wood Johnson Foundation. (2001). State Coverage Matrix. Retrieved on July 25, 2001, from State Coverage Initiatives on the World Wide Web: http://www.statecoverage.net/matrix.htm.

[18] Silow-Carroll, S., Waldman, E.K., & Meyer, J.A. (2001). Expanding Employment-Based Coverage: Lessons from Six State and Local Programs. New York: The Commonwealth Fund.

[19] Krebs-Carter, M., & Holahan, J. (2000). State Strategies for Covering Uninsured Adults. Washington D.C.: The Urban Institute.

[20] Alberga, J. (2001). Wisconsin's BadgerCare Program Offers Innovative Approach for Family Coverage. Princeton: The Robert Wood Johnson Foundation.

[21] The Robert Wood Johnson Foundation. (2001). State of the States. Princeton: Author.

[22] Polzer, Karl. (2000). Using SCHIP to Subsidize Employer-Based Coverage: How Far Can This Strategy Go? Washington D.C.: The George Washington University.

[23] Wicks, E.K., Hall, M.A., & Meyer, J.A. (2000). Barriers to Small-Group Purchasing Cooperatives. Washington D.C.: Economic and Social Research Institute.

[24] Curtis, R.E., Neuschler, E., & Forland, R. (2000). Private Purchasing Pools to Harness Individual Tax Credits for Consumers. New York: The Commonwealth Fund.

[25] Pauly, M., & Herring, B. (1999). Cutting Taxes for Insuring: Options and Effects of Tax Credits for Health Insurance. Waltham: Council on the Economic Impact of Health System Change.

[26] The Robert Wood Johnson Foundation. (2001). High-risk Pools Grow Despite Funding Challenges. Princeton: Author.

[27] Felland, L.E., & Lesser, C.A. (2000). Local Innovations Provide Managed Care for the Uninsured. Washington D.C.: Health System Change.

[28] Silow-Caroll, S., Anthony, S.E., & Meyer, J.A. (2000). State and Local Initiatives to Enhance Health Coverage for the Working Uninsured. New York: The Commonwealth Fund.

Supplemental Reference Guide

AARP. (1998). FYI: A Profile of Uninsured Persons Age 62 to 64. Washington D.C.: Author.

Academy for Health Services Research and Health Policy. (2001). Employer Buy-In Programs: How Four States Subsidize Employer-Sponsored Insurance. Washington D.C.: Author.

Alberga, J. (2001). Wisconsin's BadgerCare Program Offers Innovative Approach for Family Coverage. Princeton: The Robert Wood Johnson Foundation.

Allen, K.G. (2001). Characteristics and Trends in the Uninsured Population. Washington D.C.: United States General Accounting Office.

Alliance for Health Reform. (2000). Is Demography Destiny? Washington D.C.: Author.

Alliance for Health Reform. (2000). The Uninsured: Solving the Problem. Washington D.C.: Author.

Alliance for Health Reform. (2000). The Uninsured: The Consequences of Being Without Coverage. Washington D.C.: Author.

Alteras, T. (2001). Understanding the Dynamics of "Crowd-Out": Defining Public/Private Coverage Substitution for Policy and Research. Washington D.C.: Academy for Health Services Research and Health Policy.

American College of Physicians-American Society of Internal Medicine. Profile of the Low-Income Uninsured Who May Benefit from Tax Credits. Retrieved on July 24, 2001, from the American College of Physicians-American Society of Internal Medicine on the World Wide Web: http://www.acponline.org/hpp/uninsured.htm.

American Medical Association. (2000). Expanding Health Insurance: The AMA Proposal for Reform. Chicago: Author.

American Medical Association. (2000). Health Care in America: The Good, the Bad, and the Ugly. Chicago: Author.

Andrulis, D. & Gusmano, M. (2000). Community Initiatives for the Uninsured: How Far Can Innovative Partnerships Take Us? New York: The New York Academy of Medicine.

Arizona Health Care Cost Containment System. (2000). AHCCCS and Kidscare Members by County and AHCCCS Health Plans By County. Phoenix: Author.

Armerding, Charlotte. (2000). Arizona's Nonfarm Employment Grew 4.8 Percent Since the First Quarter '99. Phoenix: Arizona Department of Economic Security.

Birnbaum, M., (2000). Expanding Coverage to Parents Through Medicaid Section 1931. Princeton: The Robert Wood Johnson Foundation.

Bovbjerg, R.R., Marstellar, J.A., & Ullman, F.C. (2000). Health Care for the Poor and Uninsured After a Public Hospital's Closure or Conversion. Washington D.C.: The Urban Institute.

Brashears, L.R. (2000). Safeco's Select Benefits Provides Solution for Uninsured Americans. Seattle: Safeco Corporation.

Brown Ph.D., E.R., Ojeda M.P.H., V.D., Wyn Ph.D., R., & Levan M.P.H., R. (2000). Racial and Ethnic Disparities in Access to Health Insurance and Health Care. Los Angeles: UCLA Center for Health Policy Research.

Bruen, B., & Holahan, J. (1999). Slow Growth in Medicaid Spending Continues in 1997. Washington D.C.: The Kaiser Commission on Medicaid and the Uninsured.

Budetti, P., Berry, C., Butler, P., Collins, K.S., & Abrams, M. (2000). Assuring the Healthy Development of Young Children: Opportunities for States. New York: The Commonwealth Fund.

Butler, P. (2000). ERISA Complicates State Efforts to Improve Access to Individual Insurance for the Medically High Risk. Princeton: The Robert Wood Johnson Foundation.

Carbin, M.E. (Ed.). (2001). State Health Monitor, 4, 1–13.

Chollet, D.J., Kirk, A.M., & Chow, M.E. (2000). Mapping State Health Insurance Markets: Structure and Change in the States' Group and Individual Health Insurance Markets, 1995-1997. Washington D.C.: Academy of Health Services Research and Health Policy.

Clymer, A., & Pear, R. (2001, March). Congress Begins Planning for Increased Number of Uninsured as Economy Slows. The New York Times.

CNN (2000, October 19). Uninsured Hispanics Could Become Hot Political Topic. Retrieved July 9, 2001 from CNN on the World Wide Web: http://www.cnn.com/2000/HEALTH/10/19/hispanic.health.ap

Consumer Reports. (2000). Second-Class Medicine. Yonkers: Author.

Copeland, C. (1998). Characteristics of the Non-elderly with Selected Sources of Health Insurance and Lengths of Uninsured Spells. Washington D.C.: Employee Benefit Research Institute.

Coughlin, T.A., Rajan, S., Zuckerman, S., & Marstellar, J.A. (1997). Health Policy for Low-Income People in Minnesota. Washington D.C.: The Urban Institute.

Custer Ph.D., W.S., & Ketsche Ph.D., M.H.A., P. (2000). The Changing Sources of Health Insurance. Washington D.C.: Health Insurance Association of America.

Davis, K. (2001). Expanding Public Programs to Cover the Sick and the Poor Uninsured. New York: The Commonwealth Fund.

Donelan, K., DesRoches, C.M., & Schoen, C. (2000). Inadequate Health Insurance: Cost and Consequences. Hillsboro: Medscape, Inc.

Draper, D.A., Brewster, L.R., Brown, L.D., Walts, C.A., Felland, L.E., Christianson, J.B., Stoddard, J., & Park, M. (2001). Rapid Population Growth Attracts National Firms. Washington D.C.: The Center for Studying Health System Change.

Duchon, L., Schoen, C., Simantov, E., Davis, K., & An, C. (2000). Listening to Workers: Challenges for Employer-Sponsored Coverage in the 21st Century. New York: The Commonwealth Fund.

Ellis, E.R., Smith, V.K., & Rousseau, D.M. (2000). Medicaid Enrollment in 50 States. Washington D.C.: The Kaiser Commission on Medicaid and the Uninsured.

Ellwood, M. (1999). The Medicaid Eligibility Maze: Coverage Expands, But Enrollment Problems Persist. Washington D.C.: The Kaiser Commission on Medicaid and the Uninsured.

Employee Benefit Research Institute. (2000). Sources of Health Insurance and Characteristics of the Uninsured Mountain States, 1998. Washington D.C.: Author.

Employee Benefit Research Institute. (2000). The Uninsured in Southwest Border States: Q & A. Washington D.C.: Author.

Employee Benefit Research Institute. (2000). The Working Uninsured: Campaign 2000 Proposals From the Presidential Candidates. Washington D.C.: Author.

Feld Ph.D., & Power, B. (2000). Immigrants' Access to Health Care After Welfare Reform: Findings from Focus Groups in Four Cities. Washington D.C.: The Kaiser Commission on Medicaid and the Uninsured.

Friedland Ph.D., R.B., & Summer, L. (1999). Demography is Not Destiny. New York: The Commonwealth Fund.

Fronstin Ph.D., P. (2001). Hearing on Health Insurance Coverage and Uninsured Americans. Washington D.C.: Employee Benefit Research Institute.

Fronstin, Paul. (2000). Counting the Uninsured: A Comparison of National Surveys. Washington D.C.: Employee Benefit Research Institute.

Garrett, B., & Holahan, J. (2000). Welfare Leavers, Medicaid Coverage, and Private Health Insurance. Washington D.C.: The Urban Institute.

Gaumer, Ph.D., G. (Ed.). (2000). Health Watch (Fall 2000, Volume 5, Number 1). Cambridge: Abt Associates.

Health Care Financing and Organization. (2001). Cultural Bias Emerges in Reported Access to Health Care. Washington D.C.: Author.

Hoffman, C., & Schlobohm, A. (2000). Uninsured in America: A Chart Book. Washington D.C.: The Kaiser Commission on Medicaid and the Uninsured.

Holahan, J. (2001). Why Did the Number of Uninsured Fall in 1999? Washington D.C.: The Kaiser Commission on Medicaid and the Uninsured.

Holahan, J., & Kim, J. (2000). Why Does the Number of Uninsured Americans Continue to Grow? Washington D.C.: The Urban Institute.

Holahan, J., Evans, A., Liu, K., Sulvetta, M., Haslanger, K., & Cantor, J. (1997). Health Policy for Low-Income People in New York. Washington D.C.: The Urban Institute.

Holahan, J., Ku, L., & Pohl, M. (2001). Is Immigration Responsible for the Growth in the Number of Uninsured? Washington D.C.: The Kaiser Commission on Medicaid and the Uninsured.

Horvath, J. (1997). Quality Assurance in Practice—Report on a Two-State Demonstration: Interagency Collaboration for Quality Care in Medicaid Managed Care for Low Income Mothers and Children. Portland: National Academy for State Health Policy.

Hudnall, C., Barber, R., & Carbine, M.E. (Eds.). (2000). Mass. Patients' Bill of Rights Passes, But Falls Short of Universal Coverage. State Health Monitor, 4, 1–2.

Indian Health Services. (2001, February). Partnering With the Health Care Financing Administration. Retrieved from IHS on the Internet: http://info.ihs.gov.

Kenney, G., Dubay, L., & Haley, J. (2000). Health Insurance, Access, and Health Status of Children. Washington D.C.: The Urban Institute.

Kenney, G.M., Haley, J.M., & Ullman, F. (1999). Most Uninsured Children are in Families Served by Government Programs (Series B, No. B-4). Washington D.C.: The Urban Institute.

Kertesz, L. (2000, June). A Time to Sow: Strengthening Public Programs. Health Plan, pp. 62–71.

Kesich, G. (2001, June). Medicaid Called Possible Key to Wider Coverage. Blethen Maine Newspapers.

Ku, L., & Freilich, A. (2001). Caring for Immigrants: Health Care Safety Nets in Los Angeles, New York, Miami, and Houston. Washington D.C.: The Urban Institute.

Ku. L., & Coughlin, T.A. (1997). The Use of Sliding Scale Premiums in Subsidized Insurance Programs. Washington D.C.: The Urban Institute.

Lambrew, J.M. (2001). Health Insurance: A Family Affair. New York: The Commonwealth Fund.

Lamm, R.D. (1994). The Ghost of Health Care Future. Inquiry, 31(4).

Lehrer, J. (2001). National Survey on the Uninsured. Washington D.C.: News Hour with Jim Lehrer/The Kaiser Family Foundation.

Lipson, D.J., Birnbaum, M., Wall, S., Moon, M., & Norton, S. (1997). Health Policy for Low-Income People in Michigan. Washington D.C.: The Urban Institute.

Lipson, D.J., Norton, S., & Dubay, L. (1997). Health Policy for Low-Income People in Florida. Washington D.C.: The Urban Institute.

Lucas, B. (2001, May). Task Force Considers Universal Health Care. Arizona Capitol Times.

Maxwell, J., Temin, P., & Watts, C. (2001). Corporate Health Care Purchasing Among Fortune 500 Firms. Health Affairs, 20, 181–188.

Meyer Ph.D., J.A., & Zeller Ph.D., P.J. (1999). Profiles of Disability Employment and Health Coverage. Washington D.C.: The Kaiser Commission on Medicaid and the Uninsured.

Meyer, J., & Wicks, E.K. (2001). Covering America: Real Remedies for the Uninsured. Washington D.C.: Economic and Social Research Institute.

Miller, T.E., & Horowitz, C. (2000). Disclosing Doctors' Incentives: Will Consumers Understand and Value the Information? Health Affairs, 19, 149–155.

Milligan, C. (2001). Section 1115 Waivers and Budget Neutrality: Using Medicaid Funds to Expand Coverage. Washington D.C.: Academy for Health Services Research and Policy.

Mills,R.J. (1999). Current Population Reports. Washington D.C.: U.S. Census Bureau.

Minnesota Department of Health. (2000). Access to Employer-Based Health Insurance in Minnesota. St. Paul: Author.

Moon, M., Nichols, L., Norton, S., Ormond, B.A., Wallin, S., Hanson, J., & Pounder, L. (1998). Health Policy for Low-Income People in Colorado. Washington D.C.: The Urban Institute.

National Center for Policy Analysis (1995, January 9). Insuring the Uninsured. Retrieved June 12, 2001 from NCPA on the World Wide Web: http://www.public-policy.org/~ncpa/w/w18.html.

National Center for Policy Analysis (2001, October 19). Uninsured Hispanics Could Become Hot Political Topic. Retrieved July 9, 2001 from CNN on the World Wide Web: http://www.cnn.com/2000/HEALTH/10/19/hispanic.health.ap

National Conference of State Legislatures. (2000). Major Health Care Policies Fifty State Profiles. Washington D.C.: Author.

National Conference of State Legislatures. (2001). 2000 State Children's Health Insurance Program Chartbook. Washington D.C.: Author.

National Conference of State Legislatures. (2001). Small Employer Legislation: Focus on "Stripped-Down" Coverage Bills. Washington D.C.: Author.

Nichols, L., Ku, L., Norton, S., & Wall, S. (1997). Health Policy for Low-Income People in Washington. Washington D.C.: The Urban Institute.

O'Brien Ph.D., E., & Teder Ph.D., J.F. (1999). Employment-Based Health Insurance Coverage and its Decline: The Growing Plight of Low-Wage Workers. Washington D.C.: The Kaiser Commission on Medicaid and the Uninsured.

Pear, R. (2001, April). Bush Budget on Health Care Would Cut Aid to Uninsured. The New York Times.

Pear, R., & Pear, R. (1996, October). Health Costs Pose Problems for Millions, A Study Finds. The New York Times.

Perry, M., Kannel, S., & Valdez Ph.D., R.B. (2000). Medicaid and Children: Overcoming Barriers to Enrollment. Washington D.C.: The Kaiser Commission on Medicaid and the Uninsured.

Quinn, K., Schoen, C., & Buatti, L. (2000). On Their Own: Young Adults Living Without Health Insurance. New York: The Commonwealth Fund.

Rawlings-Sekunda, J. & Kaye, N. (1998). Emerging Practices and Policy in Medicaid Managed Care for People with HIV/AIDS: Case Studies of Six Programs. Portland: National Academy for State Health Policy.

Reed, J.B., & Zelio, J.A. (Eds.). (1995). States and Tribes: Building New Traditions. Washington D.C.: National Conference of State Legislatures.

Regenstein, M., & Schroer, C. (1998). Medicaid Managed Care for Persons with Disabilities: State Profiles. Washington D.C.: The Kaiser Commission on Medicaid and the Uninsured.

Rowland, D. (2001). Low-Income and Uninsured: The Challenge for Extending Coverage. Washington D.C.: The Kaiser Commission on Medicaid and the Uninsured.

Scanlon, W.J. (2001). Proposals for Expanding Private and Public Coverage. Washington D.C.: United States General Accounting Office.

Schneider, A., & Garfield, R. (2000). Medicaid Benefits. Washington D.C.: The Kaiser Commission on Medicaid and the Uninsured.

Schneider, A., Strohmeyer, V., & Ellberger, R. (1999). Medicaid Eligibility for Individuals with Disabilities. Washington D.C.: The Kaiser Commission on Medicaid and the Uninsured.

Schnieder, A., Fennel, K., & Long, P. (1998). Medicaid Eligibility for Families and Children. Washington D.C.: The Kaiser Commission on Medicaid and the Uninsured.

Shirk, M. Trost, C., & Schultz, S. (2000). In Their Own Words: The Uninsured Talk About Living Life Without Health Insurance. Washington D.C.: The Kaiser Commission on Medicaid and the Uninsured.

Spillman, B.C. (2000). Adults Without Health Insurance: Do State Policies Matter? Washington D.C.: The Urban Institute.

Storey, T. (Ed.). (2000). Is Employer-Based Health Insurance Obsolete? Phoenix: St. Luke's Health Initiatives.

Tallon Jr., J.R. (2000). The Challenge Before Us. Washington D.C.: The Kaiser Commission on Medicaid and the Uninsured.

Texas Health and Human Services Commission. (1999). Texas Medicaid in Perspective. Austin, TX: Author.

The Arizona Department of Economic Security (2000). Like Nation, Growth in Az. Slowing. Forecast, 25, 1–11.

The Arizona Department of Economic Security (2000). State Economy Continues to Chug Along. Forecast, 24, 1–8.

The Commonwealth Fund. (1998). Report Shows Enrollment Barriers and Confusion Keep Many Children Uninsured in New York City. New York: Author.

The Commonwealth Fund. (2000). Examining High Uninsured Rates Among Hispanics. New York: Author.

The Commonwealth Fund. (2000). The Commonwealth Fund: 2000 Annual Report. New York: Author.

The Commonwealth Fund. (2001). The Role of Insurance in Promoting Access to Care. New York: Author.

The Henry J. Kaiser Family Foundation and Health Research and Educational Trust. (2000). Employer Health Benefits: 2000 Annual Survey. Washington D.C.: Author.

The Henry J. Kaiser Family Foundation. (2000). Join the Debate. Washington D.C.: Author.

The Henry J. Kaiser Family Foundation. (2000). The Uninsured and their Access to Health Care. Washington D.C.: Author.

The Henry J. Kaiser Family Foundation. (2000). The Uninsured. Washington D.C.: Author.

The Kaiser Commission on Medicaid and the Uninsured. (1999). A Profile of the Low-Income Uninsured. Washington D.C.: Author.

The Kaiser Commission on Medicaid and the Uninsured. (2000). Health Insurance Coverage and Access to Care Among African Americans. Washington D.C.: Author.

The Kaiser Commission on Medicaid and the Uninsured. (2000). Immigrants' Health Care: Coverage and Access. Washington D.C.: Author.

The Kaiser Commission on Medicaid and the Uninsured. (2000). Immigrants' Health Care: Coverage and Access Key Facts. Washington D.C.: Author.

The Kaiser Commission on Medicaid and the Uninsured. (2000). The Florida Medicaid Disease Management Initiative. Washington D.C.: Author.

The Kaiser Commission on Medicaid and the Uninsured. (2000). The Uninsured. Washington D.C.: Author.

The Kaiser Commission on Medicaid and the Uninsured. (2000). Uninsured in America: Key Facts. Washington D.C.: Author.

The Kaiser Commission on Medicaid and the Uninsured. (2001). Enrolling Uninsured Low-Income Children in Medicaid and CHIP. Washington D.C.: Author.

The Kaiser Commission on Medicaid and the Uninsured. (2001). Health Coverage for Low-Income Children. Washington D.C.: Author.

The Kaiser Commission on Medicaid and the Uninsured. (2001). Immigrants' Health Care Coverage and Access. Washington D.C.: Author.

The Kaiser Commission on Medicaid and the Uninsured. (2001). Recent Immigrants Have Had Little Impact on the Growth in America's Uninsured Population. Washington D.C.: Author.

The Kaiser Commission on Medicaid and the Uninsured. (2001). The Uninsured and their Access to Health Care. Washington D.C.: Author.

The Kaiser Commission on Medicaid and the Uninsured. (2000). Uninsured in America: A Chart Book. Washington D.C.: Author.

The Kaiser Commission on Medicaid Basics. (1999). Medicaid: A Primer. Washington D.C.: Author.

The Robert Wood Johnson Foundation. (1999). $47 Million Program Seeks to Boost Number of Insured Children. Princeton: Author.

The Robert Wood Johnson Foundation. (2000). Health Insurance Coverage 2000. Princeton: Author.

The Urban Institute. (1999). How Many Americans are Uninsured? Washington D.C.: Author.

Trenholm, C., & Kung, S. (2000). Disparities in State Health Coverage: A Matter of Policy or Fortune? Washington D.C.: Academy for Health Services Research and Health Policy.

U.S. Census Bureau. (1999). Health Insurance Coverage: 1999. Washington D.C.: Author.

U.S. Census Bureau. (1999). Health Insurance Coverage: Consumer Income. Washington D.C.: Author.

U.S. Census Bureau. (2000). Health and Nutrition. Washington D.C.: Author.

U.S. Census Bureau. (2000). Low Income Uninsured Children By State: 1997, 1998, and 1999. Washington D.C.: Author.

U.S. Census Bureau. (2000). Persons Without Health Care Coverage by Geographic Division and State: United States, Selected Tears 1987–98. Washington D.C.: Author.

U.S. Department of Health and Human Services. (2000). Strategies for Retention and Reenrollment in SCHIP and Medicaid. Washington D.C.: Author.

U.S. Department of Health and Human Services. (2000). The 2000 HHS Poverty Guidelines. Washington D.C.: Author.

U.S. Department of Health and Human Services. (2001). Changing Lives Changing Communities. Washington D.C.: Author.

Walnuff Ph.D., J. (2000). The Uninsured in Arizona. Phoenix: The Flinn Foundation.

Wiener, J.M., Evans, A., Kuntz, C., & Sulvetta, M. (1997). Health Policy for Low-Income People in Texas. Washington D.C.: The Urban Institute.

William M. Mercer, Incorporated. (2001). Marketplace, Actuarial, and Qualitative Analyses of Affordable Health Insurance Coverage Options for Reducing the Number of Uninsured in the State of Delaware. Phoenix: Author.

William M. Mercer, Incorporated. (2001). Research and Analysis of Population, Health Care Program Utilization, Access to Providers, and Cost to Provide Care through State-Funded and/or Administered Programs and Related Revenues in Arizona. Phoenix: Author.

Wyn Ph.D., R. Solis M.P.H., B., Ojeda M.P.H., V.D., & Pourat Ph.D., N. (2001). Falling Through the Cracks: Health Insurance Coverage of Low-Income Women. Los Angeles: UCLA Center for Health Policy Research.

Wyn, R., Teleki, S., & Brown, E.R. (2000). Differences in Access to Health Care Among the Moderate- and Low-Income Population Across Urban Areas. Los Angeles: UCLA, Center for Health Policy Research.

Yegian, J.M., Pockell, D.G., Smith, M.D., & Murray, E.K. (2000). The Nonpoor Uninsured in California, 1998. Health Affairs, 19, 171–177.

Zuckerman, S., Haley, J., & Holahan, J. (2000). Health Insurance, Access, and Health Status of Non-elderly Adults. Washington D.C.: The Urban Institute.